PROVIDER AND CASE MANAGEMENT STANDARDS

DIVISION OF DISABILITY, AGING AND REHABILITATIVE SERVICES

THESE STANDARDS APPLY TO ALL PROVIDERS AND CASE MANAGERS PROVIDING SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES FUNDED BY THE DEVELOPMENTAL DISABILITIES WAIVER, THE SUPPORT SERVICES WAIVER, THE AUTISM WAIVER, THE AGED AND DISABLED WAIVER, TITLE XX, AND THE BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES.

Section 11 DRAFT – 6 Month Pilot

I. MISSION STATEMENT

The Division of Disability, Aging and Rehabilitative Services provides leadership and support to enable older adults and persons with disabilities to maximize their independence and self-sufficiency.

II. VALUES AND GUIDING PRINCIPLES

Delivery of quality services in an effective, efficient and timely manner;
Effective communication with staff, partners, individuals, and the community at large;
Respect, dignity, integrity and rights for all individuals;
Decision making at the levels closest to need;
Person centered planning, informed choice and individual empowerment;
Community based services;
Fiscal responsibility/good stewardship;
Performance based outcomes;
Customer satisfaction/quality customer service;
Respect for employees and providers; and
Collaborative partnerships with stakeholders.

III. INTRODUCTION

These standards apply to all providers and case managers providing services to individuals with developmental disabilities funded by the Developmental Disabilities Waiver, the Support Services Waiver, The Aged and Disabled Waiver, Title XX, and the Bureau of Developmental Disabilities Services (BDDS), which are all administered under the auspices of the Division of Disability, Aging, and Rehabilitative Services (DDARS). The standards are adopted by DDARS to ensure that providers comply with basic requirements in providing these individuals with support and assistance.

These standards do not apply to individuals with developmental disabilities residing in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) or nursing homes, which are, by Federal and State regulations, surveyed by the Indiana Department of Health. These standards also do not apply to individuals on the Traumatic Brain Injury Waiver or the Medically Fragile Children's Waiver, which provide funding for services to individuals who are eligible for nursing home level of care.

IV. INDIVIDUAL RIGHTS

Individuals have the right to a dignified existence, self-determination, privacy, and the right to be free of physical, verbal, sexual and psychological abuse, neglect or exploitation. Individuals have the right to:

A. Be informed of their rights in writing or in a manner that they can understand.
B. Exercise their constitutional, statutory, and civil rights, including the right to vote, unless limited by adjudication or finding of mental incompetence in a guardianship or other civil proceeding.
C. Advocate for themselves or designate someone else to advocate for them.
D. Receive services in a safe, secure, and supportive environment.
E. Receive humane care and protection from harm.
F. Participate in planning their services, know the effects of receiving and not receiving such services, and be informed of alternative services or habilitation programs, if any.
G. Receive services, as authorized in their individualized support plan, that are meaningful and appropriate, in accordance with standards of professional practice, guidelines and budgetary constraints.
H. Choose any qualified, approved provider and case manager to deliver their services.
I. Evaluate the services they receive.
J. Refuse to receive services if they are voluntary adults; however, certain programs require that individuals receive services to remain eligible for that program.
K. Petition the committing court for consideration of services if they are being involuntarily committed.
L. Not participate in experimental research or treatment without their informed, voluntary written consent. Individuals have the right to withdraw consent at any time.

M. Have their records treated confidentially, and give written consent before any information from their records may be released to someone not otherwise authorized by law to receive them.
N. Inspect and copy their own records at their own expense, unless denied for good cause.
O. Be treated with consideration, dignity and respect, free from mental, verbal, and physical abuse, neglect, maltreatment and exploitation.
P. Be free from discrimination in the provision of services on the basis of age, race, color, sex, religious creed, national origin, ancestry, or handicap.
Q. Practice the religion they choose.
R. Contact and consult privately with an attorney of their choice, at their own expense.
S. Consult with a doctor of their choice, at their own expense.
T. Be free from seclusion, chemical, and physical restraint, unless necessary to prevent danger of abuse or injury to themselves or others.
U. File a grievance and have access to an internal appeal process, if they feel a right has been violated, without reprisal, following the written procedure of the provider:

1. If the complaint involves a clinical treatment matter or decision, contact the primary therapist or case manager.
2. If the complaint involves a matter or decision made by another service provider, contact the provider -- the supervisor, program director, administrator.

V. A decision regarding the grievance within no more than 2 weeks.
W. Appeal decisions made by a State agency, if they disagree with the decision.
X. Exercise their “conditional right,” which can only be restricted under these circumstances:

1. In the circumstances and according to the procedures established by rules of the appropriate division.
2. Because of inconsistency with the design of a treatment or habilitation program if the program design has been approved by the division.
3. On an individual basis, only for good cause as set forth in the individual treatment record and approved by the consumer or the consumer’s legal guardian.

Y. Under their conditional rights, individuals have the right to

1. Wear their own clothes.
2. Keep and use personal possessions.
3. Keep and be allowed to spend reasonable amounts of their own money.
4. Have access to individual storage space for their private use.
5. Have reasonable means of communication with persons outside their home.
6. Be visited at reasonable times.
7. Converse privately with others.
8. Receive and send mail – unopened.

9. Have access to a reasonable amount of letter writing materials and postage.
10. Place and receive telephone calls at their own expense.
11. Be free from a requirement to work for the service provider with or without pay, except for commonly required personal housekeeping.

Z. An accounting of how the payee is spending their money (if they have a payee for their Social Security check). The payee is required by law to spend the check for their needs.

V. INDIVIDUAL RIGHTS STANDARDS

A. Providers and case managers shall have specific written policies and procedures that pertain to the services they provide and that protect and promote the individual rights listed in section IV. All personnel shall be familiar with and shall be required to follow these policies and procedures, which should include but are not limited to:

1. Informing individuals, parents (if individual is a minor or if parent is guardian), and legal guardians (when applicable) in a manner understandable by the individual, of individual rights and the rules of the provider. This information should be provided at the time when services begin and at least annually.
2. Regularly informing individuals and legal guardians (when applicable) of the individual's medical condition, developmental and behavioral status, risks of treatment, and the right to refuse treatment.
3. Ensuring individuals are free from unnecessary drugs and physical restraints, and are provided a system to reduce dependency on drugs and physical restraints.
4. Ensuring that individuals have the opportunity for personal privacy.
5. Ensuring that individuals are not compelled to perform services for the provider and that individuals who do work for the provider are compensated for their efforts at prevailing wages and commensurate with their abilities.
6. Ensuring that individuals have the opportunity to communicate, associate, and meet privately with persons of their choice and to send and receive unopened mail.
7. Ensuring that individuals have access to telephones with privacy for incoming and outgoing local and long distance calls.
8. Providing individuals the opportunity to participate in social, religious, and community group activities.
9. Ensuring individuals have the right to retain and use appropriate personal possessions and clothing.
10. Protecting individuals' funds and property from misuse or misappropriation.

B. Providers shall have a written policy and procedure that clearly prohibits abuse, neglect, mistreatment and any other violation of a person's basic human rights. The policy shall:

1. Prohibit the following:
   a) Corporal Punishment: the application of painful stimuli to the body as a penalty for certain behavior, includes, but is not limited, forced physical activity or exercise, hitting, pinching, application of painful/noxious stimuli, or the use of electric shock or other infliction of pain.
   b) Seclusion: the placement of a individual alone in a room or other area from which exit is prevented, unless it is necessary to prevent danger of abuse or injury to the individual or others or as a measure of therapeutic treatment. Therapeutic treatment could include placement in an appropriately equipped, safe time-out area for brief, programmed time segments, as part of a behavior intervention program that meets all applicable standards and has been approved by the individual, his/her guardian, the Human Rights Committee, and appropriate staff.
   c) Verbal Abuse: screaming, swearing, name-calling, belittling or other verbal activity that may cause damage to an individual's self-respect, or may reduce the individual's dignity.
   d) Any procedure which denies visitation or communication privately with family, legal representative or advocate.
   e) Any procedure that denies requisite sleep, shelter, bedding, food, drink, restriction of physical movement for prolonged periods of time, medical care/treatment, or use of bathroom facilities.
   f) Work or chores benefiting others without pay, unless it is volunteer work.
2. Include written responsibilities of employees for conducting and/or participating in investigations that involve a violation of a person's rights or a serious incident.
3. Include provisions for administrative action, disciplinary action, and dismissal of employees involved with abuse, neglect, or other human rights violations.
4. Include reporting procedures, including free access to reporting to APS.

C. Providers and case managers shall take all immediate necessary steps to prevent and protect a person who has been the victim of abuse, neglect, mistreatment or other violation of his/her basic human rights from further abuse.

D. Providers and case managers shall have written procedures for informing APS, legal guardians and/or family members of any situation involving abuse, neglect, mistreatment, or human rights violations of their family member.

E. Providers shall have a formal written grievance policy and procedure for individuals, including sharing with individuals, guardians and families the names of organizations that provide free legal assistance.

F. Providers and case managers shall have and follow written policies and procedures to protect the confidentiality of the individual's records, but allow the individual, his/her family (with the individual's permission only) or legal guardian, and DDARS staff to access those confidential records.

VI. INDIVIDUALIZED SUPPORT PLAN STANDARDS

In Indiana, it is expected that each individual with a developmental disability who is receiving long term support services funded and/or monitored by the Division of Disability, Aging and Rehabilitative Services (DDARS) of the Family and Social Services Administration (FSSA), will have an Individualized Support Plan (ISP). The development of an ISP is an integral step in the "Person Centered Planning" (PCP) process. It is developed before the budget is prepared. A realistic budget, regardless of the source of funding, should be reflective of the individual's desires and needs. The first step in the PCP process is a snapshot of an individual's dreams, hopes, desires and needs. The ISP is an attempt to translate the individual's long-range and short-range goals into reality by creatively accommodating the existing resources, both financial and human, paid and volunteer, in the form of strategies geared toward the accomplishment of such goals. Following are standards for ISP's.

A. The individualized support plan (ISP) shall be based on a person centered planning process and integrated across all programs serving the individual.

B. Case managers shall assure that the individual's ISP is based on the Person Centered Planning process and includes the following components:

1. Diagnosis;
2. Individual decision making supports;
3. Outcomes, including the following components:
    a) Desired outcomes that are clearly stated and measurable;
    b) Current status of individual in area of activity for each desired outcome;
    c) Proposed strategies/activities that provide detail as to how outcome will be attained;
    d) Clearly stated documentation identifying the responsible party who will be assisting the individual with accomplishing and maintaining the proposed strategies and activities;
    e) Clearly stated documentation identifying the qualified professional who is responsible for monitoring each service;
    f) Clearly stated documentation identifying the minimum monitoring visits needed, including type of monitoring visits (face-to-face, in the home, etc.);
    g) Data collection instructions (i.e. seizure documentation);
    h) Resources, including how activity is to be supported or funded; and
    i) Realistic, measurable timeframes for the accomplishment of each desired outcome. Timeframes should never exceed a year.

4. Types of needed supports. This section of the ISP must include anything and everything that a individual needs in his/her life to maximize personal independence, including but not limited to:
    a) Technological devices such as communication aids, mobility aids, and medical aids that support the development of daily living skills. Each individual's ISP will:

(1) document the need for devices, adaptive equipment and/or home modifications deemed necessary for safety and accessibility;
(2) identify which provider is responsible for the provision of the devices or modifications; and
(3) identify funding sources for the equipment/devices;

b) Supports for strengthening of skills such as money-management, safety-awareness/alerts, nutrition/healthy eating;
c) Transportation needs;
d) Behavioral interventions;
e) Special diets or dining needs;
f) Health needs including medication, periodic testing, specialty physician visits etc.;
g) Social/emotional supports;
h) Housing and environmental supports;
i) Safety of homes; and
j) Special employment supports.

5. List of current unmet needs of individual that are not addressed in the outcomes section of ISP, possibly due to limited funding, limited resources available to individual, or need for individual to attain other skills before goal can be achieved; and
6. ISP participants, including full names and signatures.

C. The ISP shall be updated as often as required but at a minimum annually.
D. All providers and case managers shall provide services to the individual based on the needs and wants outlined in the ISP.

VII. CASE MANAGEMENT STANDARDS

The role of case managers is to collaborate with individuals by assessing, facilitating, planning, and advocating for service needs on an individual basis. In order to successfully fulfill this role, case managers must have a working knowledge of the wants and needs of individuals receiving case management services, the array of services available, and the variety of funding resources.

For the purposes of this document, the case manager is defined as an employee of an area agency on aging, a private case management agency, or an independently employed person who has been approved by DDARS to provide case management. For individuals receiving state line-item funding only, BDDS service coordinators serve as case managers.

A. Administrative Standards

1. Case managers shall comply with all federal, state, and local law, and all Family and Social Services Administration policy, rules, regulations, and guidelines.

2. New case managers shall complete case manager orientation as approved by DDARS, prior to being eligible for Medicaid reimbursement. This standard does not apply to BDDS service coordinators.
3. Case managers shall maintain competency by completing 20 hours of DDARS approved training in each calendar year. The training shall include 10 hours of DDARS approved training and 10 hours of related training per calendar year. This is in addition to new case manager orientation. This standard does not apply to BDDS service coordinators.
4. Case managers shall provide each individual/guardian with clear and easy instructions for contacting the case manager or case manager agency. Case managers shall also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information shall be easily accessible and located with other emergency numbers, or visible from the telephone.
5. Case managers shall assure that the individual, the guardian, providers and involved agencies have copies of relevant documentation, including instructions on how to request an appeal.

B. Role of Case Manager in Individual Choice

1. Individuals and/or legal guardians shall choose their service provider(s), including case managers, and shall have the right to change any providers, including case managers.
2. Case managers shall provide to individuals and/or legal guardians a current list of potential providers and case managers, furnished by the State of Indiana, which includes services offered by each provider.
3. Case managers shall provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and shall assist the individual in evaluating potential service providers.

C. Case Management Standards for Development of ISP

1. Case managers shall work with the individual, legal guardian (when applicable) and family members throughout the person-centered planning process.
2. Case managers shall ensure that the individual or legal guardian (when applicable) identifies who they wish to serve as the decision-makers and goal setters during the person-centered planning process.
3. Case managers shall assure that person-centered planning is occurring on an ongoing basis and is formally reviewed by the case manager quarterly.
4. Case managers shall assure that the individual's ISP is developed based on the person centered planning process, and that it includes the following components:
    a) Diagnosis;
    b) Individual decision making supports;

c) Outcomes, including the following components:

(1) Desired outcomes that are clearly stated and measurable;

(2) Current status of individual in area of activity for each desired outcome;

(3) Proposed strategies/activities that provide detail as to how outcome will be attained;

(4) Clearly stated documentation identifying the responsible party who will be assisting the individual with accomplishing and maintaining the proposed strategies and activities;

(5) Clearly stated documentation identifying the qualified professional who is responsible for monitoring each service;

(6) Clearly stated documentation identifying the minimum monitoring visits needed, including type of monitoring visits (face-to-face, in the home, etc.)

(7) Data collection instructions (i.e. seizure documentation);

(8) Resources, including how activity is to be supported or funded; and

(9) Realistic, measurable timeframes for the accomplishment of each desired outcome. Timeframes should never exceed a year.

d) Types of needed supports. This section of the ISP must include anything and everything that a individual needs in his/her life to maximize personal independence, including but not limited to:

(1) Technological devices such as communication aids, mobility aids, and medical aids that aid in daily living skills. Each individual's ISP will:

(a) document the need for devices, adaptive equipment and/or home modifications deemed necessary for safety and accessibility;

(b) identify which provider is responsible for the provision of the devices or modifications; and

(c) Identify funding sources for the equipment/devices.

(2) Supports for strengthening of skills such as the money-management, safety-awareness/alerts, nutrition/healthy eating;

(3) Transportation needs;

(4) Behavioral interventions;

(5) Special diets or dining needs;

(6) Health needs including medication, periodic testing specialty physician visits etc.;

(7) Social/emotional supports;

(8) Housing and environmental supports;

(9) Safety of homes; and;
(10) Special employment supports

e) List of current unmet needs of individual that are not addressed in the Outcomes section of ISP, possibly due to limited funding, limited resources available to individual, or need for individual to attain other skills before goal can be achieved.

f) ISP participants, including full names and signatures.

5. Case managers shall ensure that the support plan is reviewed and updated at least annually, or sooner if there is a change in individuals' wants and needs.

6. Case managers shall ensure that the individual and all providers have a current, comprehensive plan of care that meets program fiscal parameters, on which services are based.

7. Case managers shall review and explain to individuals and/or guardians the services that will be provided, and the individuals and/or guardians will sign the plan to show understanding and/or agreement with the plan.

D. Case Management Monitoring Standards

1. Case managers shall monitor and document the quality, timeliness and appropriateness of care, services and products as delivered by providers, including an assessment of the appropriateness and achievement of goals as stated in each individual's ISP.

2. Case managers shall be responsible for monitoring on an ongoing basis the services and outcomes established for each individual on their caseload as detailed in each individual's ISP.

3. Case managers shall initiate timely follow up of identified problems, whether self identified or referred by others. Critical issues/crisis issues shall be acted on immediately as specified in applicable DDARS, BDDS, or BQIS policies.

4. When concerns with services or outcomes are identified, case managers shall, in a timely manner, take the necessary steps to address the concerns, including, when necessary, involving the person centered planning team. Below are guidelines for how this monitoring should occur:

a) The case manager working within their agency's internal reporting structure first contacts the provider responsible for providing the service and informs them of the concerns. The case manager and provider, using a collaborative approach, establish how the provider will address the concern and in what time frame. This initial contact should be approached by the case manager and provider as a collaborative effort to address the needs of the individual. The results of this contact should be documented in the individual's file. The collaboration should continue as the concerns are addressed, with all professionals involved documenting the steps taken to resolve the issues.

b) The case manager will continue monitoring the services provided to ensure that the provider addresses the concern within the established time frame.

c) If the concerns are not adequately addressed the case manager should determine in his or her professional judgment whether the concerns are serious enough to negatively impact the health and safety or quality of care received by the individual. If the concerns are serious, then the next step is to contact the provider in writing, documenting the concerns that have not been addressed and requesting that providers complete a written response to how they will address the concerns and in what time frame. Copies of these letters should be forwarded to the appropriate BDDS district office. **Note - this process does not replace the BDDS incident reporting process.**

d) The case manager shall continue to monitor the situation to ensure that the concerns are resolved.

e) If the concerns are still deemed serious and are still not addressed by the provider, the case manager shall forward a letter to the provider documenting the concerns that have not been addressed, the steps that have been taken by the case manager and provider to address the concerns, and the reason the concerns still exist. Included in the letter should be dates that the case manager has monitored the situation. Copies of these letters should be forwarded to the Director of BQIS, who will review each situation and develop a plan of correction or plan of action to address the concerns.

5. A maximum response time between implementation of the support plan and the first monitoring contact shall be no more than 30 calendar days or sooner if specified in the ISP.

6. Case managers shall have face-to-face contact with each individual as determined in the ISP, with a minimum of at least one visit every ninety (90) days to assess the quality and effectiveness of the support plan. A minimum of two of these face-to-face contacts per year shall be in the home setting. It is recommended that at least one visit be unannounced.

7. Case managers shall have access to providers' quality procedures for assessment purposes.

E. Case Management Documentation/File Maintenance Standards

1. Case managers shall document, in the chronological narrative, each contact with individuals and each contact with providers.

2. Case managers shall keep all files in a standardized format and sequence.

3. Case managers shall maintain privacy and confidentiality of all individual records. No information shall be released/shared with others without the individual/guardian's informed consent.

4. Case managers shall provide to the State, upon request, ready access to all case manager documentation, either electronic or hard copy.

5. Case manager documentation shall demonstrate that the safety and welfare of the individual is being monitored on a regular basis.
6. Case managers shall comply with all automation standards and requirements as prescribed by applicable agency for documentation and processing of case management activities.
7. All documentation of follow-up and resolutions of problems shall be completed in the individual record.
8. When individuals change case managers, the existing case manager shall forward all individual records/files to the new case manager within seven days of transfer.

VIII. ADMINISTRATIVE STANDARDS

A. Providers shall maintain current documentation that they have been granted approval for each service they have been approved to provide.
B. Providers shall assure compliance with all applicable state and federal regulations and requirements, including all applicable components of the Americans with Disabilities Act (ADA), and the Older Americans Act.
C. Providers shall have written documentation from the State Police verifying that all parties involved in the management, administration, and provision of services for the agency have not been convicted of a felony or an act involving:

1. Neglect, abuse or exploitation of a dependent person;
2. Abuse or fraud in any setting;
3. Mismanagement of funds;
4. Violent crime; or
5. Other actions which raise concerns regarding the provider's ability to provide services safely.

D. Providers shall maintain a corporate organizational chart (if a corporation), including parent and subsidiary corporations, which is current and will assure that DDARS has a copy of this information.
E. Providers and case managers shall follow the guidelines in the appropriate DDARS/BDDS/BAIHS provider manual for each service they are approved to provide.
F. Providers and case managers shall work in collaboration with other service providers to maintain consistency for individuals in all situations. When providers identify specific concerns with case management services, they shall, in a timely manner, take the necessary steps to address the concerns with the case manager. Below are guidelines for how this process should occur:

1. Providers, working within their agency's internal reporting structure, should first contact the case manager and inform them of the concerns. The provider and case manager, using a collaborative approach, establish how the case manager will address the concerns and in what time frame. This initial contact should be approached by the provider and case manager as a collaborative effort to address the needs of the individual. The results of this contact should be documented in the individual's file. The collaboration should continue as the concerns are addressed, with all professionals involved documenting the steps taken to resolve the issues.

2. If the concerns are not adequately addressed the provider should determine in his or her professional judgment whether the concerns are serious enough to negatively impact the health and safety or quality of care received by the individual. If the concerns are serious, the next step is to contact the case manager in writing, documenting the concerns that have not been addressed and requesting that the case manager complete a written response to how they will address the concerns and in what time frame. Copies of these letters should be forwarded to the appropriate BDDS district office. **Note - this process does not replace the BDDS incident reporting process**.
3. If the concerns are still deemed serious and are still not addressed by the case manager, the provider shall forward a letter to the case manager documenting the concerns that have not been addressed, the steps that have been taken by the case manager and provider to address the concerns, and the reason the concerns still exist. Copies of these letters should be forwarded to the Director of BQIS, who will review each situation and develop a plan of correction or plan of action to address the concerns.

G. Providers shall support practices that assist an individual served to have economic resources and insurance to protect those resources. If the provider has responsibility for the management of the individuals' funds, the following requirements shall be met:

1. Separate accounting maintained for each individual.
2. Account balances and records of transactions provided to the individual or the individual's fiscal representative as requested, but not less than quarterly.

H. Providers shall develop, implement and maintain an internal, individual driven quality assurance/quality improvement process to evaluate performance that is appropriate to the services they provide. This process shall include, at a minimum:

1. Monitoring individual satisfaction at least annually;
2. Maintaining records of the findings of annual individual satisfaction surveys and documenting efforts to improve service delivery in response to individuals' input;
3. Analysis of incident report data, development of recommendations to reduce the risk of future incidents, and review of the recommendations to assess their effectiveness; and
4. Analysis of medication errors, development of recommendations to reduce the risk of future incidents, and review of the recommendations to assess their effectiveness.

I. Providers shall have sufficient administrative resources to support each area of service delivery.

J. Providers shall not maintain offices in the home or residence of an individual.

IX. PHYSICAL ENVIRONMENT/HEALTH/SAFETY STANDARDS

In keeping with the focus on person centered planning, these physical environment/health/safety standards are based, in large part, on each individual's ISP. The ISP details the needs and outcomes of the individual, and includes safety, health and environmental needs that are specific to that person and his/her living arrangement. Therefore, these standards shall be measured against the needed supports that have been identified in the ISP. The ISP also identifies the provider responsible for provision of the supports and the case manager who is responsible for assuring the support plan has the appropriate elements and for monitoring the services provided.

A. Providers, who are identified as the responsible party in the ISP, shall ensure that appropriate devices and/or home modifications are provided to individuals, and that devices and/or modifications meet American with Disabilities Act Guidelines.

B. All vehicles which are used by providers or case managers to transport individuals shall be maintained in good repair, be properly licensed and insured as required by the State of Indiana, and comply with Medicaid reimbursement requirements, when applicable.

C. Providers , as identified in the ISP, shall instruct staff and individuals in the individuals' mode of communication the procedures to be followed in the event of an emergency/crisis situation, including:

1. Evacuation procedures;
2. Responsibilities during drills; and
3. A designated meeting place outside the residence or site of service delivery.

D. Providers shall document when an individual is medically or functionally unable to participate in procedures to follow in the event of an emergency/crisis situation and shall assure that plans to support the individual are in place if these situations occur.

E. All residential providers identified in the ISP shall assure that an emergency phone number list is located in an area visible from the telephone unless contraindicated by the ISP. The list shall include the local emergency number (911) and the individual's guardian or advocate, The ISP will detail additional telephone numbers that shall be included on the list, which may include the local BDDS office, the individual's case manager, adult protective services, and the DD waiver ombudsman.

F. All residential living areas shall meet the Indiana Code for single family dwellings or multiple family dwellings, whichever is applicable.

G. All residential living areas shall have working smoke detector(s) that are tested monthly and located in areas deemed appropriate by the local fire marshal. The ISP shall identify the responsible party for ensuring that smoke detectors are in place and tested.

H. All residential living areas shall have a working fire extinguisher that is inspected annually. The ISP shall identify the responsible party for ensuring that a working fire extinguisher is in place and inspected annually.

I. All individuals have the right to choose to live in a safe environment, which is maintained in good repair, inside and out, and is free from combustible debris, waste material, offensive odors, rodents and insects. Providers and case managers who assess that an environment may be unsafe for individuals shall take the appropriate steps to ensure that the individual is safe, including, when appropriate, filing an incident report and working with the individual and the person centered planning team so that the issues can be resolved.

J. The provider shall have **specific written health and safety policies and procedures** that are applicable to the services they are providing, and that all personnel are familiar and are required to follow. These policies and procedures include, but are not limited to:

1. The installation of anti-scald devices or lowering water heater temperatures to 110 degrees when an individual or housemate's ISP indicates the need for such a device;
2. Notification of law enforcement agencies;
3. Evacuation drills;
4. Procedures to follow during emergency/crisis situations which include:
    a) Tornadoes;
    b) Fires;
    c) Behavior exacerbations;
    d) Elopements; and
    e) Snow.
5. Medication administration. The ISP shall address medication administration needs for the individual, including assessment of the ability to self-medicate. Providers identified in the ISP as responsible for administration of medications shall have policies and procedures that include at a minimum:
    a) An organized system for drug administration that includes:
        (1) Identification of each drug;
        (2) Documentation that medication is administered only by trained and authorized personnel, unless the individual is capable of self-administration of medication based on an assessment;
        (3) Documentation of the administration of drugs which includes date, time and initials of staff;
        (4) Procedures for destruction of unused medication; and
        (5) Documentation of medication errors, which includes the process providers have in place to minimize the recurrence of such errors.
    b) Guidelines for the storage of medication that ensures that medication is, when determined necessary in an individual's or housemate's ISP:
        (1) Stored in a locked area. (Medications requiring refrigeration shall be stored in a locked container in the refrigerator.);
        (2) Stored separately from non-medical items;

(3) Stored under proper conditions of temperature, light, humidity, and ventilation; and
(4) Stored in and dispensed from the original labeled prescription container.

6. Development of dining plans for individuals with swallowing difficulties, as outlined in the ISP.
7. Seizure management, as outlined in the ISP, that shall include:
   a) Direct care staff training on administration of medication, including identification of side effects;
   b) A seizure tracking form that includes documentation of events immediately preceding each seizure, during the seizure, and immediately after the seizure;
   c) Documentation of physician follow-up and follow along; and
   d) Medication levels checked at least annually or more frequently as ordered by physician.
8. An internal review process for any reportable incident as defined in the BDDS incident reporting policy. This process should include:
   a) A trend analysis of incidents for each individual; and
   b) Documentation that summarizes the findings of the analysis and the steps taken to minimize the occurrence of incidents in the future.
9. When an individual death occurs, an investigation into the death by the primary provider that includes:
   a) Contacting BDDS Central Office within 24 hours by telephone to notify them of the death and notifying BDDS and APS within 24 hours as required by the BDDS Incident Reporting Policy;
   b) A summary of what occurred for at least a 72-hour period before the death;
   c) A review of staff's actions immediately preceding the death;
   d) Conclusions and recommendations from the investigation;
   e) Documentation stating how the recommendations, if any, were implemented; and
   f) A final report that includes all the above information (except [d]) and is provided to DDARS Bureau of Quality Improvement Services within 30 days of the death.
10. Providers shall have a policy that limits the use of highly restrictive procedures such as physical restraint and drugs for behavioral support. The policy shall focus on the approach that behavioral interventions should move from least to more intrusive/restrictive steps with documented evidence that the least intrusive methods have been attempted and exhausted first. Furthermore, highly restrictive procedures should be used only in situations where the following conditions are met:
   a) The individual's team, including a behavior specialist, the individual, their legal representative or advocate as appropriate, the case manager and the Human Rights Committee concur that the use of the highly restrictive intervention is required to prevent significant harm to the individual or others. The team shall weigh the risks of the behavior

against the risks of the intervention and there shall be documentation that systematic efforts to replace the behavior with an adaptive skill have been demonstrated and found to be ineffective. There shall also be documented informed consent from the individual or his/her legal representative. This should be outlined in ISP.

b) An individualized written plan for behavioral support that includes the physical restraint, based on a functional analysis of the behavior, has been developed by the individual's team and approved by a Human Rights Committee prior to implementation. That committee must review the plan at least every three months. This should be outlined in ISP.

c) The behavior plan is carried out under the supervision of a behavior specialist who meets the requirements of DDARS. (Supervision does not require direct 1:1 oversight, but oversight through other staff involvement and receiving reports of the individual's progress).

d) The plan shall contain written guidelines for teaching the individual functional and useful behaviors to replace the maladaptive behavior and shall include non-aversive methods of teaching those behaviors.

e) When drugs that are not necessary for a mental illness or seizure control are used for a behavior, there shall be a plan for drug reduction or documentation that a drug reduction plan has been implemented and proven ineffective. The individual's physician shall approve the drug reduction plan or provide documentation that the medication cannot be reduced. This drug reduction documentation shall be part of the behavior support plan and outlined in the ISP.

f) The staff person responsible for carrying out the plan has received specific training, from the behavior specialist, in the techniques and procedures required by the plan and training and demonstrated understanding is documented.

g) In case of an emergency, physical restraints and removal from the environment may be used, but only to prevent significant harm to the individual or others. The team must meet to review any incidents of such occurrences and determine the need for a functional analysis and necessity of a behavior support plan.

K. Providers implementing a behavior support plan for individuals must establish a Human Rights Committee comprised of persons with disabilities, family members, volunteers, advocates and people who have experience or training in human rights. At least one third of the voting members shall not be employed by the provider. The Human Rights Committee shall:

1. Review, approve and monitor:

a) The outcomes of interventions within individual plans which might restrict the individuals' rights;

b) Providers' plans and procedures that involve risks to the individuals' rights and protection, including but not limited to, the use of psychotropic medications or aversive techniques administered to control or modify behavior; and

c) Meet as necessary, but at least quarterly, and shall keep minutes for each meeting.

L. Providers and case managers identified in the ISP will coordinate the health care received by individuals, including:

1. Appropriate preventive health care, including annual physical, dental, and vision examinations, immunizations, and routine screenings as dictated by physician; and
2. Appropriate follow-up or emergency health care.

M. Providers shall follow specialized diet programs identified in the ISP with appropriate assessment and oversight.

X. FISCAL STANDARDS

A. Providers shall maintain and make available to DDARS information regarding their:

1. Financial position,
2. Current expenses and revenues,
3. Budgets outlining future operations, and
4. Ability to sustain services including credit history or ability to obtain credit.

B. Providers shall be fiscally stable, with the documented ability to deliver services without interruption for a minimum of 2 months without payment.

C. Providers shall maintain financial records in accordance with generally accepted accounting and bookkeeping practices.

D. Providers' financial status shall be audited by an independent Certified Public Accountant according to State Board of Accounts requirements.

E. Providers, when providing vocational/habilitation services, shall secure insurance to protect the personal property of individuals, to cover injury or loss of life caused by fire, accident or other dangers, which might arise in the operation of the provider.

F. Providers shall secure liability insurance for all vehicles owned or leased by the provider.

G. Providers shall bill for reimbursement in compliance with the following:

1. Services reimbursable through Medicare or Medicaid to eligible persons must be billed through those programs, and reimbursements from these sources must be considered the total payment for claims. These services cannot also be billed through the State contract for additional reimbursement. This does not include Medicaid spend down, when required.
2. No state funding will augment other funding sources;
3. Services reimbursable through Vocational Rehabilitation Services funds cannot be billed concurrently through other DDARS' funds (including BDDS), until Vocational Rehabilitation is no longer funding the service.
4. Reimbursements through private insurance must be considered total payment. These same services cannot be billed through DDARS' funding for additional reimbursement.

5. Services reimbursable through other funding sources must exhaust that funding prior to consideration for state line item funding.
6. The contracted provider and its subcontractors shall impose no fees upon the individuals for any services provided through this agreement without prior written approval of the State. This does not include Medicaid spend down, when required.

XI. PERSONNEL STANDARDS

A. Providers shall have qualified personnel to provide support services to meet the needs of individuals choosing the services they offer. In addition, staff shall meet the requirements for those services per the DDARS Supported Living Service Definitions and Standards (Appendix A).
B. Providers shall provide direct care staff training that includes, at a minimum, the following components:

1. Individual rights, including:
    a) Respect and dignity;
    b) Abuse, neglect, and exploitation;
    c) Person centered planning and support plan;
    d) Individual, family member, and guardian responsibilities;
    e) Communication methods; and
    f) Legal status.
2. Health and Safety, including
    a) Medication administration;
    b) First aid;
    c) CPR;
    d) Infection control;
    e) Universal precautions; and
    f) Individual specific health information, including:
        (1) Seizure management
        (2) Behavior management, including interventions
        (3) Medication side effects
        (4) Diet and nutrition
        (5) Swallowing difficulties
        (6) Crisis control and management
        (7) Significant health concerns.

C. Providers shall maintain records to document each employee's

1. Successful completion of orientation and direct care staff training, signed and dated by both employee and trainer.
2. Successful completion of all in-service training (dates of training, content, signature of employee and trainer).
3. Current negative TB test or chest x-ray, updated annually.
4. Current CPR certification, recertification updated annually.
5. Current auto insurance (if employee will be transporting individual).
6. Criminal background check verifying no convictions for abuse, neglect or exploitation of an individual. The background check shall be repeated at least every 3 years for the duration of employment.

D. Providers shall maintain personnel policies, reviewed and updated as appropriate, and distributed to the staff. Such policies shall include at least the following:

1. Written job descriptions including minimal qualifications for each position, major duties, responsibilities, and reporting supervisors and positions supervised.
2. Written procedure for conducting reference, employment, and criminal background information on all perspective employees.
3. Written provision excluding the employment of any person convicted of abuse, neglect or exploitation of any individual.
4. Evidence of professional licensure or certification, including renewals, as applicable.
5. Written process for evaluating the job performance of each staff member at the end of his/her training period and annually thereafter, including a process for individuals' input in this process.
6. Description of disciplinary procedures and grounds for dismissal.
7. Description of the rights and responsibilities of staff, including the responsibilities of administrators and supervisors.

E. Providers shall have specific written policies and procedures with which all personnel are familiar and are required to follow, including, but not limited to:

1. Providing orientation for all new employees to assure their understanding of and compliance with the mission, goals, organization and practices of the provider.
2. Maintaining clear documentation of training for each staff person, noting type of training provided, name and qualifications of trainer, length of training, date completed, and the trainer's and employee's signatures verifying completion.
3. Ensuring that all trainers have sufficient education, expertise, and knowledge of the subject material to achieve the listed outcomes.
4. Providing annual in-service training to improve staff competence in the following areas:
    a) Abuse/neglect/exploitation;
    b) Individual rights;
    c) Incident reporting; and
    d) Medication administration.

F. Providers shall maintain a written operations manual that includes all policies and procedures.

XII. RECORD/DOCUMENTATION STANDARDS

A. All DDARS providers shall maintain, in each individual individual's file, located at individual's residence or primary location of services:

1. Individual's personal information, including:
    a) Name;
    b) Emergency telephone numbers;
    c) Intake sheet with specific information regarding individual's diagnosis, treatment, medications, etc.;

d) History of allergies;
e) Consent for emergency treatment;
f) Photograph of individual; and
g) Brief summary of individual information that includes:
(1) Diagnoses;
(2) Current medications;
(3) Pertinent health information;
(4) Pertinent behavioral information; and
(5) Individual likes and dislikes.

2. The individual's current support plan, waiver plan of care (if applicable) and behavior plan (if applicable).
3. List of services to be provided and budget for services.
4. Documentation of services rendered in individual's residence or primary location of care for **the current 90 days**, including, when applicable:

a) Copy of Habilitation Plan based on the ISP and progress notes for the most recent 90 days that include:
(1) Measurement of individual's progress for each goal;
(2) Dates and times of services;
(3) Length of time the service continued;
(4) Description of activities; and
(5) Signature of the staff providing the service that day.
(Earlier notes should be maintained in an office file.)
b) Chronological notes for non-habilitation services, including:
(1) Respite Care documentation that includes:
(a) Date and amount of time spent with individual;
(b) Location of respite;
(c) Type of respite (home health aide, attendant, etc);
(d) Reason for respite; and
(e) Signature of staff person who provided the service.
(2) Homemaker, Attendant Care, Personal Assistance, Residential Care, Community Residential Services, Personal Care, and/or Adult Companion documentation that includes:
(a) Date;
(b) Times of arrival and departure;
(c) Specific activities performed while in the individual's home; and
(d) Signature of staff person who provided the service.
(3) All other non-habilitation services (i.e. occupational therapy, physical therapy) documentation that includes:
(a) Dates and times of services;
(b) Description of activities; and
(c) Signature of staff person who provided the service.

c) Copy of Behavior Support Plan (if applicable) and behavior management notes that are based upon positive behavioral support principals and that include:

(1) Dates and times of behavior management consultant visit;
(2) Length of time the service continued;
(3) Description of activities;
(4) Description of behavior progress;
(5) Signature of staff providing the service that day; and
(6) Targeted behaviors, including:

(a) Dates and times of occurrence of targeted behavior;
(b) Length of time behavior lasted;
(c) Description of what precipitated the behavior;
(d) Description of what activities helped alleviate the behavior; and
(e) Signature of staff providing services during the exacerbation.

d) Documentation of any changes in individual's physical condition, mental status, or any unusual event, including but not limited to vomiting, choking, falling, disorientation or confusion, behavior problems, or seizures. Included in this documentation should be staffs' response to the observed change or event.

5. Financial records which should be available for most recent 3 years including:

e) Individual's check book with clear documentation that is has been balanced;
f) Bank statements with clear documentation that it has been reconciled;
g) Documented accounting for any cash on hand; and
h) Documentation that the checkbook is balanced each month by someone other than the staff member assisting with the checkbook.

B. All DDARS providers shall maintain, in each individual's file, located at providers office:

1. Individual's personal information, including:
   a) Name and social security number;
   b) Emergency telephone numbers;
   c) Intake sheet with specific information regarding individual's diagnosis, treatment, medications, etc.;
   d) History of allergies;
   e) Consent for emergency treatment; and
   f) Photograph of individual (when appropriate).
2. Where applicable, the individual's current support plan, rehabilitation plan, plan of care and/or behavior plans.
3. List of services to be provided and budget for services.

4. Documentation of services rendered in individual's residence or primary location of care for last seven years, including, when applicable:

a) Copy of Habilitation Plan and progress notes for a seven year period that include:

(1) Measurement of individual's progress for each goal;
(2) Dates and times of services;
(3) Length of time the service continued;
(4) Description of activities; and
(5) Signature of the staff providing the service that day.

b) Financial records, when the individual's habilitation goals include bill-paying and other fiscal issues, including:

(1) Individual's check book;
(2) Bank statements; and
(3) Documentation that the checkbook is balanced each month by someone other than the staff member assisting with the checkbook.

c) Chronological notes for non-habilitation services, including

(1) Respite Care documentation that includes:

(a) Date and amount of time spent with individual;
(b) Location of respite;
(c) Type of respite (home health aide, attendant, etc); and
(d) Reason for respite.

(2) Homemaker, Attendant Care, Personal Assistance, Residential Care, Community Residential Services, Personal Care, and/or Adult Companion documentation that includes:

(a) Date;
(b) Times of arrival and departure; and
(c) Specific activities performed while in the individual's home.

(3) Adaptive Aids and Devices, assistive technology, specialized medical equipment and supplies, and or PERS documentation that includes:

(a) Installation date;
(b) Dates of maintenance (where applicable); and
(c) Any changes to existing equipment, including alterations, corrections, or replacements.

(4) Adult day Service documentation that includes:

(a) Dates and times of services;
(b) Specific activity provided (on-site as well as community trips); and
(c) The degree that the individual participated.

(5) Home Delivered Meals documentation that includes:

(a) Number of meals delivered in given week;
(b) Dates delivered;

(c) Whether or not supplements were given or a special diet was noted or modified; and
(d) Verification that menu plans were reviewed and approved by a registered dietician.

(6) All other non-habilitation services (i.e. occupational therapy, physical therapy) documentation that includes:
(a) Dates and times of services;
(b) Description of activities; and
(c) Signature of staff person who provided the service that day.

d) Copy of Behavior Plan (if applicable) and behavior management notes that include:
(1) Dates and times of behavior management;
(2) Length of time the service continued;
(3) Description of activities;
(4) Description of behavior progress;
(5) Signature of staff providing the service that day; and
(6) Targeted behaviors, including:
(a) Dates and times of occurrence of targeted behavior;
(b) Length of time behavior lasted;
(c) Description of what precipitated the behavior;
(d) Description of what activities helped alleviate the behavior; and
(e) Signature of staff providing services during the exacerbation.

e) Documentation of any changes in individual's physical condition, mental status, or any unusual event, including but not limited to vomiting, choking, falling, disorientation or confusion, behavior problems, or seizures. Included in this documentation should be staffs' response to the observed change or event.

5. For individuals who receive a residential living allowance, documentation that the individual's residential living allowance has been deposited in individual's account.
6. For individuals in Supported Living settings, receipts for all expenditures made from individual's financial resources and food stamps, including rent, utilities, groceries, clothing, household goods, etc.
7. Receipts to document expenses made with individual's start-up money (for individuals who have start-up money).
8. Most recent Diagnostics & Evaluation (D & E) report, when applicable.
9. Individualized community living budget (ICLB) for individuals in Supported Living settings.

C. All DDARS providers shall maintain, in employees files in provider's office:
1. Documentation that employees have completed orientation and direct care staff training, signed and dated by both employee and trainer.

2. Documentation that employees have completed all in-service training (dates of training, content, signature of employee and trainer).
3. Current negative TB tests or chest x-rays, due annually.
4. Current CPR certifications, recertification due annually.
5. Copies of current driver's licenses.
6. Copies of current auto insurance (if employee will be transporting individual).
7. Criminal background checks repeated at least every 3 years after employment.
8. Copies of current license (such as therapists, nurses etc).
9. Employees time cards.
10. Agendas of all staff training, which include:
    a) Specific information included in training session;
    b) Dates and times of training;
    c) Length of time training continued;
    d) Trainer; and
    e) Signatures of staff who attended.

XIII. DEFINITIONS

Abuse: Physical, sexual, verbal, mental or psychological abuse

1. physical – includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain
2. sexual - includes all allegations of rape, sexual misconduct, sexual coercion or sexual exploitation
3. verbal – includes oral, written, and/or gestured language that includes disparaging and derogatory remarks to individuals
4. mental - includes unreasonable confinement, intimidation, humiliation, harassment, threats of punishment or deprivation whereby an individual suffers psychological harm or trauma

Advocate – one who is independent of paid providers and who assists the person with decision making and other aspects of self-determination

Area Agency on Aging (AAA) - a local entity that contracts with the State to perform a variety of functions in providing services to individuals with disabilities and aged persons

Annual review - a review of an individual's services which may include visits and/or conversations with the individual, family or advocate, and service providers, assessment of skills, and a review of available documentation of an individual's progress on goals and objectives or other reports

Adult Protective Services (APS) - a program administered by the Family and Social Services Administration and implemented by selected county prosecutors, operating as regional APS units, who have been contracted to investigate reports of suspected abuse, neglect, and exploitation of vulnerable adults as defined by IC 12-10-3

Bureau of Aging and In-Home Services (BAIHS) – provides a broad range of in-home and community based services to older adults and persons of all ages with disabilities.

Bureau of Developmental Disabilities Services (BDDS) – plans, develops, and administers a variety of services for people who have developmental disabilities.

Bureau of Fiscal Services (BFS) – supports all DDARS operations with budget, fiscal and contract management.

Bureau of Quality Improvement Services (BQIS) – continually assesses the quality of services of the three program bureaus and recommends improvements.

Bureau of Rehabilitation Services (BRS)– supports eligible individuals with disabilities in their efforts toward attaining and maintaining self-sufficiency. Includes:

- Blind and Visually Impaired Services – assists citizens who are blind and visually impaired to achieve personal and vocational independence.

- Deaf and Hard of Hearing Services – advocates for and provides access to services for persons who are deaf or hard of hearing.
- Disability Determination Services – determines eligibility of Hoosiers for Social Security and Supplemental Security Income Disability benefits.
- Vocational Rehabilitation Services – provides quality, individualized services to enhance and support people with disabilities to prepare for, obtain or retain employment

Bureau of Strategic Support Services (BSSS) – supports the division and bureaus in the areas of policy review and program development, community capacity/relations, and training.

BDDS District Manager - an employee of the BDDS responsible for the coordination of services in a prescribed area

Budget Modification Request (BMR) - a form used to request temporary (90 days or less) increases in an Individual Community Living Budget (ICLB) that is already approved and in effect

Commission on the Accreditation of Rehabilitation Facilities (CARF) - the commission that compares the standards of vocational and habilitation providers to national standards for purposes of accreditation

Care plan -the individual service plan noting the amount and kind of specific services, the provider of services, and the kinds of activities that should occur during service delivery

Case management - the activities involved in locating, managing, coordinating and monitoring:

- All authorized services
- Needed medical, social, functional, and other publicly funded services regardless of funding source
- Informal community supports needed by eligible persons and their families

Case Manager – An employee of an area agency, a private case management agency, or an independently employed person who provides case management. For individuals receiving state line-item funding only, BDDS service coordinators serve as case managers.

Certification - documentation of an individual's eligibility status, medical needs, and need for services for persons with a developmental disability

Community based services - services provided primarily in natural environments in the community as opposed to services provided primarily in segregated sites

Developmental disability criteria (Medicaid State Plan) - the criteria established in the Title XIX of the Social Security Act State Plan i.e. a person with a developmental disability has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition, other than mental illness, closely related to mental retardation in that the impairment of general intellectual functioning or adaptive behavior is similar to that of mental retardation. The condition is manifested prior to the age of twenty-two (22), is likely to continue indefinitely, and requires the person to have twenty-four (24) hour supervision. As a result of the condition, the person has substantial functional limitations in three or more of the following major life areas: self-care, understanding and use of language, learning, mobility, self-direction, and/or capacity for independent living.

Developmental disability criteria (State) - means a severe, chronic disability that:

1. is attributable to a mental impairment or physical impairment, or a combination of mental and physical impairments (other than a sole diagnosis of mental illness);
2. is manifested before the individual is twenty-two (22) years of age;
3. is likely to continue indefinitely;
4. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration and are individually planned and coordinated; and
5. results in substantial limitations in at least three (3) of the following:
    - self-care
    - receptive and expressive language
    - learning
    - mobility
    - self-direction
    - capacity for independent living
    - economic self-sufficiency

Division of Disability, Aging, & Rehabilitative Services (DDARS) – Is part of the Family and Social Services Administration (FSSA) within the government of Indiana and consists of the following entities:

- Bureau of Developmental Disabilities Services (BDDS)
- Bureau of Rehabilitative Services (BRS)
- Bureau of Aging and In-Home Services (BAIHS)
- Bureau of Fiscal Services (BFS)
- Bureau of Strategic Support Services (BSSS)
- Bureau of Quality Improvement Services (BQIS)

Eligible - an administrative status in which it has been determined and documented by an employee of DDARS that an individual meets certain criteria

Endangered adult - an individual who is at least eighteen (18) years of age, incapable by reason of mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs, or other physical or mental incapacity, of managing or directing

the management of the individual's property or providing or directing the provision of self-care, harmed or threatened with harm as a result of neglect, battery, or exploitation of the individual's services or property

Entitlement - benefits to which individuals that meet certain criteria have a right to receive

Environmental Modifications – Services that provide safe access into and within the home and facilitate independence and self-reliance for an older adult or a person with disabilities. Environmental modifications may include:

- Installation of lifts or ramps
- Installation of grab bars
- Widening of doorways
- Modification of kitchen or bathroom facilities

Exploitation - includes:

1. financial – any deliberate misplacement, exploitation, or wrongful temporary or permanent use of an individual's belongings or money
2. Any other type of exploitation, including but not limited to sexual exploitation

Family and Social Service Administration (FSSA) - the primary social service agency of the State of Indiana containing several divisions and offices with responsibilities for services affecting individuals

Functional assessment - an evaluation designed to determine or identify an individual's current capacity to perform activities of daily living such as self-care, independent living, and communication skills

Generic supports - supports and services generally available to anyone in the community

Guardian – A person who is a fiduciary and is appointed by a court to make decisions for an incapacitated person. This includes a temporary guardian, a limited guardian, and a successor guardian. I.C. 29-3-1-6.

Habilitation services – Essential services designed to maximize the functioning level of persons with disabilities in order to develop and retain capacity for independence, self-care, and social functioning. These services are coordinated through a program of objectives designed to obtain goals related to diversion of an individual from an institutional placement or enabling deinstitutionalization of the individual, as well as meeting active treatment needs.

Habilitation plan - a formal description of goals, objectives, and strategies (including desired outcomes, timeframes, and persons responsible for implementation) designed to enhance skill acquisition and increase independence that has been developed for a specific individual

Inclusion - a situation or method of interaction in which individuals with developmental disabilities are routinely incorporated into activities shared by other members of the community

Individual – for the purpose of this document, an individual is a person with developmental disabilities receiving services funded by the Developmental Disabilities Waiver, the Support Services Waiver, The Aged and Disabled Waiver, Title XX, or the Bureau of Developmental Disabilities Services (BDDS).
Individual Community Living Budget (ICLB) - a format used by BDDS to uniformly account for all of the service and living costs, sources and amounts of income and benefits, and other financial issues related to the individual and to approve the allocation of state dollars to fund certain services

Individualized Support Plan - In Indiana, it is expected that each individual with a developmental disability who is receiving long term support services funded and/or monitored by the Division of Disability, Aging and Rehabilitative Services (DDARS) of the Family and Social Services Administration (FSSA), will have an "Individualized Support Plan". The development of an individualized support plan is an integral step in the "Person Centered Planning" (PCP) process. It is developed before the budget is prepared. A realistic budget, regardless of the source of funding, should be reflective of the individual's desires and needs. The first step in the PCP process is a snapshot of individual's dreams, hopes, desires and needs. Some of the techniques used for this have been Personal Futures Planning; Mapping; PATH; and Lifestyle Planning. The individualized support is an attempt to translate the individual's long-range and short-range goals into a reality by creatively accommodating the existing resources, both financial and human, paid and volunteer, in the form of strategies geared toward the accomplishment of such goals.

Integrated - a situation or setting in which persons without disabilities make up more than fifty (50) percent of the group in which individuals with disabilities enjoy the opportunity to work and interact in the community

Maladaptive behavior - behavior that is not pro-social or puts an individual at risk of self-injury or injury to others

Natural supports - supports that are already in existence and not artificially created that enhance skill acquisition, promote independence, and foster meaningful relationships between a person with a developmental disability and a member of a community such as those provided by family, friends, and neighbors without formal reimbursement

Neglect – includes failure to provide supervision, training, appropriate care, food, medical care or supervision

Ombudsman - a representative who receives, investigates and attempts to resolve complaints of individuals (or their families) being served on one of the Medicaid waivers for persons with a developmental disability

Office of Medicaid Policy and Planning (OMPP) - an entity within FSSA with the responsibility of allocation and oversight of all services funded by Medicaid

Outcome - a result or consequence of goals and objectives and planned activities that can be used to measure an individual's progress and satisfaction in the acquisition of functional skills and competencies and in developing meaningful relationships

Person centered planning - a process whereby persons with developmental disabilities and their families direct the planning and allocation of resources to meet their own life goals. The personal life plan:

- Should be based on the person's preferences, dreams, and needs
- Understands how the person makes decisions
- Understands how a person is and can be productive
- Discovers what a person loves and dislikes
- Understands a person's preferences
- Encourages and supports long-term hopes and dreams
- Is supported by a more short-term support plan based on reasonable costs given the person's support needs
- Includes individual responsibility
- Includes a range of supports including funded, community, and natural supports
- Should be developed and updated at least annually

Plan of care/cost comparison budget - a specific Medicaid Waiver document that includes information on the services, budget, and providers for an individual on one of the Medicaid Home and Community-based Waivers

Provider - a person or entity chosen by the individual and authorized by the funding source that is paid to provide an agreed upon service or services at a specified time and place. For this document providers do not include case managers.

Residential living allowance (RLA) - funds authorized by BDDS intended to meet the basic needs of individuals based on the total monthly living expenses minus the individual's total monthly income and benefits

State line item - a funding source authorized by BDDS using 100% state dollars

Service Coordinator - an employee of BDDS with the responsibility to perform various job functions related to the planning, coordination, and oversight of services for persons with a developmental disability. Service Coordinators have the role of Case Managers for individuals receiving state line-item funding only.

Support team - individuals who know and work with the person being served and who are committed to the development and implementation of his/her support/service plan

Supported living - an approach in which services and supports are designed specifically to meet an individual's needs as opposed to an approach in which an individual is placed into a setting where a prescribed constellation of services is available

Vocational/habilitation provider - a provider of habilitation, vocational, or other services commonly provided outside the individual's residential setting in a segregated site or in the community (sometimes referred to as a "day service provider")

Waiver - any one of several Medicaid programs in which services that normally must be provided in licensed setting may be provided in unlicensed settings